In The Abstract

A quarterly newsletter from the Kentucky Cancer Registry

Large Hospital Edition April, 2001

KCR BECOMES A SEER REGISTRY!!

Below are paraphrased excerpts from the Louisville Courier Journal newspaper regarding this important designation.

Thursday, February 15, 2001

.....The Kentucky Cancer Registry is becoming part of a prestigious network of cancer sites nationwide supported by the National Cancer Institute, the federal government's main agency for cancer research.

The cancer institute announced recently that it was expanding its network of 11 locations by four-Kentucky, California, New Jersey and Louisiana. All of the sites collect detailed cancer statistics used by researchers and public health scientists.

A cancer institute spokesman said that including Kentucky in the network will assure that people who live in rural areas are more accurately represented. Until now, for example, 89 percent of those in the population covered by the network were urban residents. Nationwide, 75 percent of Americans are urban dwellers. The centers in the cancer institute's Surveillance, Epidemiology and End Results Program had covered about 14 percent of the U.S. population. With the four added sites, the institute will be getting cancer statistics from about a quarter of the population.

We at the central registry wish to congratulate you- the registrars- as this honor is a direct consequence of your outstanding work! The only registries that were allowed to submit applications to become part of the SEER expansion were those that already meet high standards for data quality. The Kentucky Cancer Registry was invited to become part of the SEER Program because we have a state with dedicated and talented hospital-based cancer registrars. Your work is recognized for its quality and excellence.

KCR Eliminating Follow-up Requirements for Pre-1995 Cases

Thomas Tucker, Director, Kentucky Cancer Registry, recently announced that Kentucky hospitals reporting to KCR will no longer be required to conduct annual follow-up on cases diagnosed prior to 1995 effective immediately. This will allow KCR to continue to estimate 5 year survival rates and simultaneously assist registrars in reducing their ever increasing workload.

For those hospitals whose cancer programs are ACoS approved, however, the hospital would have to request a change in reference date to 1995 from ACoS in order to be able to eliminate the follow-up of the pre-1995 cases. It should be noted that changes in reference date by the College are only granted once every 5 years. While some registrars may not be able to take advantage of this reduction in workload immediately, it should be kept in mind for the future.

CEU's for KCR Regional Workshops

A total of 5.5 CEU's have been requested from NCRA for attendance at the recent workshops held in Madisonville, Lexington, and Louisville to discuss changes effective with 2001 cases. (See the next newsletter for the number approved.) In addition, April Fritz, Data Quality Manager, Seer Program will be holding a two day workshop for Kentucky registrars on the following dates:

May 8 & 9	-	Hampton Inn	Elizabethtown
May 10 & 11	-	Hampton Inn	Lexington

These workshops will cover the following topics:

1. SEER Program: Commitment to Data Quality and Quality Requirements
2. ICD-O-3 Coding Exercises and Discussion
3. Casefinding Exercises and Discussion
4. Treatment Coding Exercises and Discussion
5. EOD Coding Exercises and Discussion
6. Open Forum - Questions and Answers

CEU's will also be requested for this workshop from NCRA. KCR will cover one night's hotel expense for registrars who need to travel out of town for this two day session. An expense reimbursement form will be included in the packet you receive at the workshop. A receipt will need to be submitted with the form and sent to Candy Robinette at KCR for reimbursement. Registrars are asked to share a room whenever possible. Registrars are strongly encouraged to

attend one of these sessions and to submit questions and suggestions in advance to make this workshop meaningful and beneficial for you! Being part of the SEER Program means increased opportunities to improve data quality and to provide registry data for national surveillance and research. This training is being offered to prepare all registrars for the upcoming changes in cancer reporting requirements for 2001 and to improve your skills as a cancer registrar.

Speaker/Topic Ideas
KCR Fall Workshop

Plans are underway for KCR's annual workshop to be held at the Hilton Suites - Lexington Green on September 27 and 28. We would be very pleased to receive suggestions from you regarding excellent speakers and topics that we might consider for the program. Also, many of you have indicated a desire for more presentations by other registrars regarding daily operations and "HOW TO"..... information. Submit your ideas to your regional coordinator or contact Judi Cook at the central registry. This is <u>your</u> workshop. Won't you help us to make it a beneficial one for all?

PEOPLE NEWS

Welcome to New Hires:

★	Nazarelle Tate	Lourdes Hospital, Paducah
★	Kim Ratliff	University of Kentucky Hospital, Lexington
★	Frances Koon	Kings' Daughters Medical Center, Ashland
★	Leonard Frazier	St. Luke East, Fort Thomas
★	Tom Dobbins	King's Daughters Medical Center, Ashland

<u>ACoS Cancer Program Approvals</u>

Congratulations to the following for receiving full 3 year approvals:

1) Mahr Cancer Center, Madisonville
   Stacy Littlepage, CTR and Teresa Ford, CTR Registrars

2) Owensboro Mercy Health Systems, Owensboro
   Rhonda Paul, CTR, Julie Simmons, and Betty Lindsey, CTR Registrars

GOLDEN BUG AWARD

Special thanks to the following for discovering more of those pesky software bugs:

Natascha Lawson	Norton Hospital, Louisville
Donna Warwick	Caritas Medical Center, Louisville

ACoS to Require "Ideal Path Report"

Effective in 2002 the American College of Surgeons has announced its intent to require all ACoS approved cancer programs to use the College of American Pathologists (CAP) standard protocols for reporting complete, accurate and uniform information on pathologic specimens.

Attached is a sample from a Kentucky hospital of the approved protocol for breast (partial mastectomy) as dictated by the pathologist according to the protocol guidelines. Can you imagine having all of this information documented in this standard format on each and every surgical case of cancer you abstract?!

The cancer protocol manual, *Reporting on Cancer Specimens: Protocols and Case Summaries,* is available for sale ($45 for CAP members/$60 for non-members). In addition, protocols will be posted on the web at www.cap.org/html/publications/cancerfactsheet.html for those who do not want to purchase the entire binder. The manual is a collection of 22 CAP-approved cancer protocols, written for surgical pathologists, that explains procedures that should be followed in identifying and describing tumors in various sites of the body including the breast, prostate, colon, and rectum, stomach, kidney, vagina, thyroid gland, and lung. Each protocol is written in two versions: a long form with explanatory notes and a short form or checklist that gives all the information needed for a pathologist to create a complete report and fill out the tumor staging form used by the clinician. Only the long forms are free via the web. The short forms are included in the binder for purchase.

In addition, a supplement of 10 more protocols is available for sale ($20 for CAP members/$25/non-members). The supplement's protocols also appear on the Web. They are: anus, extraheptic bile duct, gallbladder, liver, pancreas (endocrine), small intestine, vulva, Hodgkin's disease, non-Hodgkin's lymphoma, and adrenal gland.

EOD CODING CORNER

The following questions and answers regarding EOD coding were taken from the SEER web site **http://seer.cancer.gov** (under Scientific Systems) are being offered in an effort to continue registrar training in the rules and application of the EOD system. Registrars may access the SEER INQUIRY SYSTEM (SINQ) to review questions and answers; however, questions cannot be directly submitted to SINQ by individual registrars. Your questions should be submitted to Frances Ross through the regional coordinators. Frances will submit the question to SINQ and forward the response back to the appropriate individuals.

Question: In cases where the tumor has both invasive and in-situ components, the pathologists usually do not report a size for invasive portion. In most cases, the invasive portion is described as a percentage of the tumor mass.

What should be recorded as tumor size when the pathology report does not specify dimensions for the invasive component?

Answer: If the size of invasion is not given, and the total tumor size is <1cm, you can use code 009. In general if a tumor is described as <1cm, code as 009.

If the total tumor is <2cm, you can use code 019. In general if a tumor is described as <2cm, code as 019.

If the tumor mass is >2cm, code size as 999 as stated in the EOD manual, "If only one size is given for a mixed in situ and invasive tumor, code size is 999, unknown."

KCR Note: Tumor size from a document other than the path report (i.e. mammogram) should not used when it is known that the tumor has both in situ and invasive components.

Question: "General Guidelines. "Except for tumor size, extent of disease information obtained from treatment with neoadjuvant chemotherapy, hormone or immunotherapy has begun may be included.

Was radiation therapy intentionally excluded from this statement?

Answer: Radiation therapy was inadvertently omitted from the list.

Question: How is size code 000 used?

Answer: Use 000 when a tumor of a stated primary site is not found, but the tumor has metastasized.

Example: Ductal carcinoma found in axillary lymph nodes. No tumor found in breast on physical exam or by pathological exam of the breast, but physician states that the breast is definitely the primary site. EOD size code would be 000.

Paget's disease for breast carcinoma with no underlying tumor is coded to 997 not 000.

Do not use 000 in the size field when a tumor is not visible on physical exam or by imaging, but tumor is found microscopically. Example: Inspection of the cervix shows no visible tumor; biopsy of the cervix reveals CIN III or squamous cell carcinoma, either invasive or in situ. If no size of tumor is given on pathology report, size code is 999.

Question: For lung cancers, the size given in an x-ray and the size given in a scan often differ.

What are the rules for coding size of tumor when the chest x-ray and chest scan show different sizes for a lung tumor?

Discussion: How should tumor size be coded for the following lung cancer:

2/11/91 CXR: 3.5 cm RUL lung lesion
2/12/91 CT: 2.0 cm RUL lung lesion

Is a CT more accurate than chest radiographic exam, or should the larger size be selected?

Answer: Code the larger size; tumor size is 3.5 cm in this case.

KCR Note: This does not coincide with ACoS requirements. Effective with 2001 cases registrars need to follow the SEER rule above.

Question: How should we interpret “subcarinal extension: with no mention of nodes in coding EOD for lung cancer? Would this be “70", mediastinal extension?

Answer: Yes, code as mediastinal extension, 70.

Question: For lung primaries, do we code 1, 2, or 9 in the SEER lymph node involvement field when a chest x-ray states there is a mediastinal mass or a hilar mass but there is no further evaluation.

Answer: Code 9 for a hilar mass and 2 for a mediastinal mass. Note 7 says: If at mediastinoscopy/x-ray the description is mediastinal mass/adenopathy or enlargement of any of the LN named in LN code 2..., assume that it is involved mediastinal nodes.

Question: For bladder cancers the pathologic description of TURB specimens is often limited to statements such as “no muscle invasion” or “without muscle invasion.”

What EOD extension code should be assigned for these cases?

Answer: Assign code 15, invasive tumor confined to subepithelial connective tissue.

Question: The pathology report is frequently the only information we have to code prostate cases.

What are the minimum criteria we need to document a clinical extension code 30 (localized, NOS)?

Discussion: What information do we need to be able to assign a clinical stage for prostate cancer (physical examination, laboratory tests, scans, etc.).

Answer: Code what you know. Use code 30 unless it is known that there is additional staging information that you have not been able to access.